THE LONG OVERDUE MEDICAL SPECIALTY: BIOETHIATRICS

Jack Kevorkian, MD
Royal Oak, Michigan

Traditional bioethical codes have been unable to cope with the results of modern technology and the drastic changes in life patterns. The medical profession can reestablish bioethical order and reassert leadership through a new and urgently needed medical specialty, which the author tentatively calls bioethiatrics or bioethiatry. Bioethiatrics embodies a unique combination of ethical action and moral judgment.

Training for the specialty would start with a residency program, consisting of thorough training in philosophy and religion coupled with continued experience in clinical medicine and indoctrination in contemporary research. Requirements would include the practice of general medicine for at least two years after internship, the passing of oral and written examinations after four years of residency, board certification, and subsequent periodic evaluations.

Bioethiatricians would assume all the usual privileges, obligations, and risks associated with the practice of any medical specialty, thereby averting unnecessary ethical crises and ensuring a more rational response to present and future moral challenges.

Astonishing medical progress made possible by the marvels of technology has exposed the inadequacy of traditional bioethical codes to cope with the resultant profound moral dilemmas. An atmosphere of confusion amid increasingly frequent crises has led to a medley of uncoordinated responses by nonphysician ethicists, harried legislators, and faceless ethics committees.[1,2] In the din, the medical profession seems to be retreating into a "bunker type" mentality,[3] relinquishing control of its ethical prerogatives to other segments of society.[4,5] Somewhat belatedly, it has made an attempt to reassert leadership by sponsoring a conclave that focused on several aspects of the current crisis in medical ethics.[6] But there is little doubt that a real and lasting solution will entail more than occasional symposia, which suffer crippling limitations of scope and continuity and especially relevance to the demands of specific cases.

The ultimate answer is to be found in a combination of two significant developments in recent medical history that undergird the superb quality of medical practice today. The first took place immediately after the turn of the present century and dealt with laying the groundwork for assured medical competence (then drowning in a welter of all sorts of dubious sects and their ubiquitous "practitioners").[7] The second occurred later, and for a variety of reasons (chiefly technological progress and a more knowledgeable public), matured into the now indispensable fragmentation called specialization.[8]

CREATING A NEW MEDICAL SPECIALTY

The yearning[1] and need[8] for some sort of new medical specialty is being openly expressed. In creating a new medical specialty of conventional type, the profession will have set the stage for engendering the certainty and competency needed to restore bioethical order and will have established enduring leadership. Just as with any other medical specialty, this new one, too, could be called upon by any practitioner facing an unforeseen and very knotty ethical problem to help ". . . unearth new evidence, or reinterpret the data already amassed, to reach an ["ethical"] diagnosis or evaluate ["ethical"] treatment".[9]

What should the new specialty be called? Ethics

is far too general a branch of axiology, and therefore too vague and nonspecific a term. Bioethics is more specific, but still not specific enough because the matter at hand concerns not all of biology, or even zoology, but rather humanity alone. A combination of words or syllables would seem to be in order, preferably from Greek. But first, one more point should be stressed: whereas all nonphysician ethicists are by law (and common sense) restricted to passive philosophizing, only their physician counterparts have the additional privilege (and advantage) of *acting* to apply the "medicine" of ethical deliberation to the treatment of individuals. With the established examples of words such as pediatrics and psychiatry in mind, it is only logical to call the new specialty "bioethiatrics" or "bioethiatry," and its duly trained and certified practitioner a "bioethiatrician" or a "bioethiatrist."

The founders of any new organization gain membership by means of a so-called grandfather clause. Initially, a new Board of Bioethiatrics or Bioethiatry would have to consist of currently active bioethicians who are known to espouse broad views, free of philosophical constraints and ecclesiastical dogma, especially when making professional judgments or taking professional action. An absolute prerequisite would be board domination and control by duly licensed and competent *physician* bioethicians who have never been officially censured, imprisoned, or found guilty of culpable practice. There is little doubt that situational or casuistic ethics[10] will predominate in the personal views of such board members and in the formulation of their own specialty's code.

ACCREDITED TRAINING

Candidates for residency training in the proposed specialty will have to manifest similar ethical flexibility as a basis for maximum objectivity in an ever-changing world. After graduating from an accredited medical school and completing a full year of rotating internship, all candidates must spend at least two more years as civilians in general medical practice. Residency itself should be three, and preferably four, years. It will encompass intimate knowledge of all significant religions, both in theory and from on-site observation of, and sometimes participation in, actual rites. Furthermore, every bioethiatric resident will become thoroughly acquainted with recorded patristic and secular philosophy. Meanwhile, he or she will spend a great deal of time honing clinical acumen in a general hospital by working on medical and surgical wards and attending various conferences. There will also be close liaison with scientists active at the frontiers of medical research.

Board certification would require passing comprehensive written and oral examinations. Continued certification would depend on periodic reexamination. Finally, a special journal published under aegis of the board would not only help guarantee maintenance of proficiency, but also serve as a rich thesaurus for guidance in revision of ethical codes and in enactment of laws.

The recommendation that physicians dominate the board and be the only candidates for training and certification is not a mere "chauvinistic" ploy. Every sensible person would admit that it is much simpler and cheaper to train a physician in ethics and philosophy[11] (which are solely didactic) than to train a humanist in medical art and science (which entail much more than books and thought). In the final analysis it is *medical* theory or action that is the crux of any biomedical problem with regard to any patient individually (and collectively through them with regard to society). From this, it follows that the skill and knowledge of a competent physician are more basic and should reign supreme.[3]

PRACTICAL SCENARIOS

A comparison with extant medical specialties will dispel all doubt about the practicability of the proposed concept and how it might relate to everyday affairs. When a patient complains of a visual field defect, he may first consult a generalist. Now, even though the latter is privileged to do further diagnostic and therapeutic maneuvers, and surgery if necessary, we all agree that it would be foolish for him to do so. Instead, the sensible generalist must rely on a certified ophthalmological consultant to verify the diagnosis of, say, pituitary tumor. The specialist now finds himself in the generalist's prior position, and wisely forsaking his legal prerogative, he calls upon yet another consultant to perform the ameliorating craniot-

omy. The generalist, the ophthalmologist, the public, the courts, and all of society readily acknowledge that their combined talents and educational and advisory expertise cannot override deference to the board-certified neurosurgeon.

For an analogy, let us consider another scenario that has become commonplace. Assume that a board-certified bioethiatrician existed when Karen Quinlan lay comatose and sustained by extraordinary means, which the family wanted discontinued. Instead of precipitating the unfortunate controversy that actually ensued, the family's request could have been referred by attending physicians to the hypothetical bioethiatrician. After in-depth interviews with the next-of-kin, analysis of the entire family situation, review of the patient's clinical course as recorded in the chart, thorough examination of the patient, and consultation with colleagues in other pertinent specialties, the bioethiatrician would use his or her abilities to make the necessary diagnosis of inescapable and imminent biologic death due to an irretrievably vegetative state and to write the necessary orders to accomplish the called-for "treatment." As with the ophthalmologist and the neurosurgeon in the first example, here the bioethiatrician would undertake the obligation to make the decision and assume some of the unique risk of his specialty—freeing everyone else of such burdens. After all, that is why specialism developed, and that is the only way an increasingly complex system of medical care can function efficiently, if at all. In the second example, too, nothing and nobody could justifiably override or gainsay the preemptory role of the board-certified bioethiatrician.

COMMENT

Such specialists most assuredly would have averted the demeaning sensationalism of recent right-to-die litigation as well as the Baby Doe and Baby Fae controversies. Such unfortunate events can only lead to more unpopular and even deleterious governmental regulations that tend to merely compound dilemmas. It is probably true that public notoriety attendant to the controversies should decline when the profession demonstrates decisiveness.[4] Just as every disease process is never identical in separate individuals, so too, every ethical problem is distinctly unique and relative to any solitary case. Every medical specialist is free within the bounds of accepted medical norms and secular law to distill from his expertise any principle or personal "law" he deems applicable to the nuances of any contingency in the treatment of his patient. The surgeon himself decides if, when, and how to operate—not a committee. The obstetrician himself decides if, when, and how to deliver—not a committee. The same should hold true for our proposed bioethiatrician, who can thereby relieve harrassed legislators of their onerous and sometimes harmful approach to "solving" ethical dilemmas, and in so doing, he or she can serve as their unwavering guide to making truly sensible and fruitful legislation.

Critics will undoubtedly point out the great danger of concentrating so much power (life-or-death decisions) in one person and the ever-present threat of abuse of that power. Of course, critics purposely exaggerate both points. Such criticism is neither new, nor should it be disquieting. It applies equally well to every human invention, concrete or abstract; and humans are fallible (including, of course, the critics). Honest mistakes are to be expected in every aspect of life, but that is no reason to forswear anything. When abuses occur we are obligated to learn from them and to incorporate what we learn into continuously updated codes and laws to forestall further abuse.[12] After all, concepts do not misbehave, persons do. Should the practice of surgery be abandoned because some surgeon abused it? Should the office of the presidency of the United States be abolished because it was abused by the commission of a felony? And if the drafters of the US Constitution were told by critics that the proposed office of the presidency represented the potential abuse of too much power vested in a single individual, should they have rejected the concept of presidency? One can imagine how that would have affected our republic. But imagination is not needed to discern clearly the debilitation of our bioethical milieu, which such unthinking criticism would perpetuate and even deepen.

Lest one nonchalantly dismiss the proposal as being patently absurd, he or she should bear in mind that today's legitimate specialties of rheumatology and gerontology were just as "patently" absurd to the practitioners of 75 years ago.[9] How-

ever, the accelerating pace of progress now allows much less time to correct that kind of mistaken judgment born of ignorance and lack of imagination. The longer this sort of definitive and "curative" action is put off, the greater the likelihood of more governmental paternalism in the form of ill-advised and hasty regulations.

CONCLUSIONS

Sooner than one might guess, the medical profession and society at large will face overwhelming moral decisions in connection with sanctioned euthanasia and suicide, brain transplants, transspecies gestation, human cloning, and the unforeseen progeny of molecular and genetic engineering. These profound problems will demand and get immediate attention and action. The medical profession had better be ready, not simply to participate but instead to guide and control a sublime mission rightfully in its domain.

Literature Cited

1. Purtillo RB. Ethics consultations in the hospital. N Engl J Med 1984; 311:983-986.
2. Koop CE. The Right To Live; The Right To Die. Wheaton, Ill: Tyndale House, 1976, pp 17, 41, 58, 71, 116.
3. Hurst RA. More physicians need to take active leadership roles—Particularly now. Am Med News, January 24/31, 1986, p 36.
4. Lee PP. Ethics, law, and medicine: Today's crossroads. The Pharos, Winter, 1986, pp 12-14.
5. Cranshaw R. 'Society must decide'—Oregon health decisions: Biovaluation beyond bioethics. West J Med 1986; 144:246-248.
6. Rust M. 'New medicine' raises troubling questions. Am Med News, March 28, 1986, pp 9-11.
7. King LS. Medical education: Elitisms and reform, historical vignettes. JAMA 1983; 250:2457-2461.
8. Raanon G. Where respect for autonomy is not the answer. Br Med J 1986; 292:48-49.
9. King LS. Medical practice: Specialization, historical vignettes. JAMA 1984; 251:1333-1338.
10. Raanon G. Deontological foundations for medical ethics? Br Med J 1985; 290:1331-1333.
11. Caplan A. Applying morality to advances of biomedicine. In: Bondeson WB, Engelhardt T, Spicker S, et al, eds. New Knowledge in the Biomedical Sciences: Some Moral Implications of Its Acquisition, Possession, and Use. Hingham, Mass: D Reidel, 1982, pp 155-168.
12. McIntyre N, Popper K. The critical attitude in medicine: The need for a new ethics. Br Med J 1983; 287:1919-1923.